Nursing Facility Fraud and Abuse

Why look at nursing homes?

- Beneficiaries are often not aware of items that are billed to Medicare under their Medicare Health Insurance Claim Number.

- Generally, no Explanation of Medicaid Benefit forms are sent to Medicaid recipients so, unlike with Medicare, it is hard for recipients or their families to check whether Medicaid has been billed correctly for services provided.

- Beneficiaries are often not able to participate in decision-making regarding their medical treatment.

- There may be a lack of oversight of supply inventory or stockpiling of supplies.

- Staff may not be well versed in scams to defraud Medicare.

Reason you may be reluctant to report suspected nursing facility fraud and abuse:

Fear of retaliation against the resident in a nursing facility may prevent reporting of suspected fraud or abuse. Calls to the various regulatory and law enforcement agencies to report such suspicions must be kept confidential.

MEDICAID PATIENT ABUSE OR NEGLECT:

Elderly persons or persons with disabilities living in nursing homes may be the victims of physical, emotional, sexual or financial abuse. Neglect of patients or residents can constitute abuse as well.

The federal regulations for long-term care facilities state that, "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care (42 CFR 483.25 Quality of care)." **Failure to provide that level of care, while billing Medicare or Medicaid for covered services, is the basis for fraud actions against long-term care facilities.**

In Arkansas, the Attorney General's Medicaid Fraud Control Unit (MFCU)[1] investigates and prosecutes providers who commit Medicaid fraud, and investigates and brings to justice those who abuse the elderly and disabled in our nursing homes.

The authority to protect nursing home residents derives from the Adult Abuse Act of the Arkansas Criminal Code (§ 5-28-101), which forbids abuse, exploitation and/or neglect of the elderly. According to the Arkansas Attorney General, "Physical abuse or neglect is any action or failure to act that causes unreasonable suffering, misery, injury or harm to a resident of a health care facility licensed by the Office of Long Term Care...anything from striking or sexually assaulting a patient to withholding necessary and adequate food, physical care or medical attention. Financial abuse includes the misuse of a resident's trust funds to pay for nursing home services already being paid for by the Medicaid program or for uses of a patient's funds not authorized by either the resident or the resident's guardian, trustee, administrator, etc."[2]

---

[1] The federally funded Arkansas law enforcement agency that investigates and prosecutes Medicaid provider fraud and violations of state laws pertaining to fraud in the administration of the Medicaid program. They also review complaints of patient abuse and neglect and of misappropriation of patient funds in all residential healthcare facilities that receive Medicaid funds and, if appropriate, investigate and prosecute the people responsible. The Arkansas MFCU is staffed by attorneys, investigators and auditors trained in the complex litigation aspects of healthcare fraud and patient abuse and neglect. They are required to be separate and distinct from the state Medicaid program.

[2] Medicaid fraud & Elderly Abuse, Office of the Arkansas Attorney General, *http://www.ag.state.ar.us/medicaid/abuseneglect.htm.*

As defined in the Arkansas Adult Abuse Act (§ 5-28-101), **ABUSE IS:**

1. Any intentional and unnecessary physical act which inflicts pain on or causes injury to an endangered or impaired adult, including sexual abuse;
2. Any intentional or demeaning act which subjects an endangered or impaired adult to ridicule or psychological injury in a manner likely to provoke fear or alarm; or
3. With regard to any adult resident of a long-term care facility by a caregiver, any willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

NEGLECT IS:

1. Negligently failing to provide necessary treatment, rehabilitation, care, food, clothing, shelter, supervision, or medical services to an endangered or impaired adult;
2. Negligently failing to report health problems or changes in health problems or changes in the health condition of an endangered or impaired adult to the appropriate medical personnel;
3. Negligently failing to carry out a prescribed treatment plan; or
4. Failing to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness as defined in regulations promulgated by the Office of Long-Term Care to an adult resident of a long-term care facility.

EXPLOITATION IS:

1. The illegal use or management of an endangered or impaired adult's funds, assets, or property, or the use of an endangered or impaired adult's power of attorney or guardianship or person for the profit or advantage of himself or another, or
2. Misappropriation of property of an adult resident of a long-term care facility which means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent.

Examples of Arkansas Abuse Cases[3]

- A 92-year-old resident of a small town nursing home was raped by a male certified nursing assistant, employed at the facility even though he had a criminal history.
- Using a bar of soap that was placed in a sock, an aide repeatedly beat a mentally retarded resident of a human development center because the aide wanted to sit in the reclining chair that the resident was sitting in. The facility supervisor then violated the law by not reporting the abuse because he did not want to fill out the required paperwork.
- A convicted felon working at a facility struck a 99-year-old resident in the jaw because the resident was combative.
- A 21-year-old male nursing aide was convicted of raping an 89-year-old resident who had no physical ability to protect herself from this sexually abusive caregiver.
- A mentally retarded resident of a human development center was choked by a male aide because the resident would not eat all of his meal.
- A female employee of a facility for developmentally disabled children forced a small child to eat his own vomit after the child vomited during his feeding.
- On Christmas Day, a nursing home resident was abused by a nurse when the nurse literally jumped on the resident because he failed to comply with the nurse's orders.
- A female nursing aide slapped one resident and spit in the face of another resident because the residents acted in a combative manner.
- A male employee of a facility for the mentally retarded forcibly performed oral sex on a mentally retarded male resident.

[3] Medicaid Fraud & Elderly Abuse, http://www.ag.state.ar.us/

Examples of Arkansas Neglect Cases[3]

- A female nursing aide was captured on videotape dumping out trays of food meant for residents because she did not want to take up any of her time feeding the residents.
- A nurse failed to give tube feedings and medication to an elderly resident as ordered by a physician. The resident had no other way to receive any sustenance.
- A nurse gave two residents ten times the amount of insulin ordered by the physician. This massive overdose resulted in the death of one of the residents and the hospitalization of the other resident.
- A female resident was forced to lie in her own feces after an aide refused to help the resident from the bed into a "potty chair." The aide even ridiculed the resident after she soiled herself.
- A mentally retarded resident of a human development center was left in his own feces after a male aide refused to clean the resident. The aide then hid this fact from other employees. The feces, which was spread all over the back, legs, and head of the resident, was allowed to dry before the resident was cleaned.
- Many residents of a nursing home went for weeks without their vital signs and blood pressure taken because an aide did not want to properly do her job. She stated that the vital signs did not have be taken because the residents were eventually going to die, whether she took the vital signs or not.

The Health and Human Services Office of the Inspector General (OIG) is using the False Claims Act to test the theory that **"failure to provide the care that's covered by the contract can rise to the level of failure to give the government what it's paid for...The theory stems from quality of care cases involving nursing homes. Deliberate understaffing and**

multiple incidents of failure to provide care have given the feds implicit falsity cases against nursing homes."[4]

For example, in 2003 the Arkansas Attorney General's Medicaid Fraud Control Unit (MFCU) reached a $1.5 million settlement with Beverly Enterprises, Inc. after an 18-month investigation found "evidence of neglect, injuries and failure to provide nursing care and treatment for vulnerable nursing home residents,"[5] indicating Medicaid fraud. This settlement will result in nearly $6 million of additional funding for Arkansas' Medicaid programs.

For example, in 2002 the MFCU settled a case against Longmeadow Nursing Center in Malvern, AR arising from a complaint that a nursing home resident's foot was neglected until infection of the leg required amputation above the knee. Longmeadow agreed to pay $50,000, with an additional $75,000 suspended pending the completion of in-service training in wound care, pest control, and proper documentation.[6]

For example, Ila Swan, an advocate for nursing home reform, brought an unprecedented qui tam[7] or "whistleblower's" lawsuit against a national nursing home chain "for defrauded taxpayers by taking Medicare money while giving substandard care to nursing home residents. The lawsuit alleged that ManorCare, Inc. (which operates 300 nursing home in 31 states) did not meet the standards of the Nursing Home Reform Act of 1987 – by failing to respond to patient call lights, allowing patients to lie in

---

[4] *Truth in Claims Extends To Quality Of Care,* Hospital Compliance Wire (1/6/2002).

[5] *Attorney General's office reaches $1.5 million settlement*, AR News Bureau (3/5/03).

[6] AR Office of the Attorney General, FOR IMMEDIATE RELEASE, APRIL 2, 2002.

[7] A law known as the False Claims Act allows whistleblowers to bring "qui tam" lawsuits — basically civil fraud lawsuits filed on behalf of the government — against companies and individuals that are cheating the government. Liable defendants in qui tam cases must pay the government for its losses and pay penalties for fraud. A whistleblower who brings a successful qui tam case under the False Claims Act is entitled to a reward, which is based on the amount of money the government recovers. Some of the types of fraud against the government that can be the basis of a qui tam lawsuit include Medicare fraud, Medicaid fraud, defense contractor fraud, customs fraud, bid-rigging on government projects, environmental fraud and research fraud. "Qui tam" is short for the Latin phrase – "qui tam pro domino rege quam pro se ipso in hac parte sequitur" – which translates as "he who brings an action for the king as well as for himself."

their own waste for hours, and permitting them to develop bedsores from unsanitary conditions and malnutrition."[8] Previously Swan won a whistleblower's lawsuit against Crestwood Convalescent Homes of California, returning more than $800,000 in Medicare money to the federal government and taxpayers.[9] It was the largest ever qui tam lawsuit settlement for quality of care issues.

Fraud schemes:

- **Falsification of records to support improper billings:**

  For example, in 2000 Beverly Enterprises negotiated a $175 million settlement for Medicare fraud (the Largest Settlement Ever Reached For a Nursing Home Case).[10] According to the Department of Justice (DOJ), Beverly "incorporated defrauding Medicare as part of their overall business strategy."[11] From 1992-98 Beverly defrauded Medicare of $460 million "by fabricating nursing cost figures based on set formulas designed to maximize profits while avoiding detection by Medicare auditors."

- **Providing medically unnecessary physical, occupational and speech therapies (PT, OT, ST).** Therapies may be provided to groups of patients in nursing facilities but billed to Medicare as if they were provided individually. **For example**, a physical therapist spends 30 minutes with a group of ten patients and Medicare is billed for 30 minutes of PT for each patient.

- **GANG VISITS when doctors or other healthcare practitioners bill for services for all or nearly all residents.** The physician may never even render the service, he may see some but not all the residents, or he may provide a service to all residents whether they need it or not. In that case, many or most of the patients do not have any prior symptoms or condition warranting the practitioner's service.

---

[8] *Activist Sues National Nursing Home Chain,* Los Angeles Times (5/9/01).
[9] *Nursing home whistle-blower files suit again,* Los Angeles Times (5/10/01).
[10] *Beverly pays $175 Mil for Medicare Fraud,* Reuters (2/3/00).
[11] *Why departure of nursing home giants is good news*, Barbara Hengstebeck, Tallahassee Democrat (10/26/02).

- Physicians bill for comprehensive physical examinations without ever seeing the resident.

- Physicians falsify medical records to indicate that nonexistent services were rendered.

- **Billing social activities as psychotherapy**

- **Billing for medical supplies not provided to the patient.** When a patient is not under a Medicare Part A covered stay, facilities may bill for certain medical supplies under Part B.

- **UPCODING – Billing for supplies that are more expensive than the ones actually required or used.**

  For example, Irrigation kits may be supplied to nursing facilities for ostomy patients in quantities far greater than needed. In many cases, sterile kits are not medically necessary. Nursing homes can then break kits down and stockpile the individual components in their central supply area.

  For example, suppliers have billed Medicare for custom-fitted body jackets when the actual items supplied were plain, wrap-around corsets secured by Velcro straps. Reimbursement was often several hundred dollars per patient for an item that cost $30.

- **KICKBACKS –** an arrangement between two parties, which involves an offer **to pay for** Medicare or Medicaid business. Health care providers engaging in kickback activities are subject to criminal prosecution and exclusion from the Medicare and Medicaid programs.

  For example, An Illinois man found himself behind bars for Medicare fraud and facing a civil False Claims Act lawsuit for scheming to supply nursing home residents with medically unnecessary incontinence supplies. The defendant pled guilty to conspiring to violate the anti-kickback statute by making illegal payments to two

Chicago-area nursing home owners. He will pay $175,000 to reimburse the Medicare program in this case of **"Diaper fraud."** [12]

- **DRUG DIVERSION**, which deprives the patient of proper medication while defrauding the Medicaid program (**for example**, a staff person throws away the patient's medication, sells it or takes it for personal use).

  According to the Associated Press, "stealing medicated pain relief patches off the backs of elderly patients...is an increasingly common type of drug abuse." "For many years, fentanyl was actually the drug of choice of the addicted anesthesiologist," said Dr. Joel Nathan of the Addiction Recovery Institute in New York. "Outside of that, **we are probably talking mostly about low-paid people in the nursing industry, like nursing aides and other uncertified health care workers."**[13]

  For example, the family of a Montana woman who was deprived of pain medication in the last four months of her life settled a lawsuit against the nursing home where the administrator allegedly stole the elderly resident's transdermal pain patches to feed her own drug addiction. The lawsuit charged the owners of the facility with negligence in hiring, retaining and supervising the facility administrator, and overlooked her prior drug problems because she was their daughter. The nurses at the facility began to suspect that she was taking pain patches from the patient but "allegedly did not report their suspicions "because of her relationship with the owners and her marriage to the local chief of police."[14]

  For example, a nurse at St. Clare Home for the Aged in Newport, RI went to prison in 2002 for pilfering pain-relieving medication from three patients. A lawsuit filed against the nursing home asserted that St. Clare hired the nurse without requesting details of her criminal record, which would have revealed a prior conviction for stealing

[12] *Illinois Fraudster Faces Legal Double Whammy,* CHICAGO, Medical Newswire (9/24/02).
[13] *Abuse of pain patches on the rise, officials say,* AP Newswires, PA (3/29/02).
[14] *Family of deceased nursing home resident settles pain patch suit,* Andrews Online (8/22/03).

morphine from a terminal hospice patient. They then tried to cover up her behavior to avoid embarrassment.[15]

Things to look for:

- **Signs of physical abuse, sexual abuse and criminal neglect**, such as unexplained injuries, a patient's fear of being alone with direct care staff, reports of physical abuse or physical signs of sexually transmitted diseases, malnutrition, and any form of retaliation for a resident's behavior.

- **Every patient has the same medical equipment** (e.g., the same brand and type of wheelchair, walker, etc.). It is highly unlikely that almost every patient within a facility will need the exact same medical equipment. But, it happens in some fraud schemes. This is why it is important to notice these things when you visit a nursing facility. In order for a patient to receive medical equipment or supplies, a physician must certify that they are medically necessary.

- **Double billing on durable medical equipment (DME).** The government may be paying twice for the same equipment. Medicare pays on behalf of each patient and Medicaid factors the cost of DME into the per diem rate that it establishes for specific patients.

- **Therapies (PT, OT, ST) being provided to groups of patients.** Check to see if these services are being billed to Medicare as if provided individually.

- **Therapies (including psychotherapy) being provided to patients who cannot benefit from the services** (especially Alzheimer's patients or patients in a coma).

- **Frequent and recurring "routine visits" by the same medical professional.**

[15] *Nursing home faces negligence suit,* Providence Journal, AP Newswires (11/7/02).

- Patient file access provided to persons who are not actual practitioners for specific patients, or health care practitioners who are given or request unlimited access to residents' medical records.

- Kits marked for individual patients that are used for other patients or held in common storage areas. This may indicate that unnecessary supplies are being ordered or that necessary supplies are being provided in a quantity greater than required for the patients with documented medical need.

It is in your best interest and that of all citizens to report suspected fraud. Health care fraud, whether against Medicare, Medicaid or private insurers, increases everyone's health care costs, much the same as shoplifting increases the costs of the food we eat and the clothes we wear. If we are to maintain and sustain our current health care system, we must work together to reduce costs.

Report Suspected Abuse to the Arkansas Medicaid Fraud Control Unit (MFCU).

If you have reason to believe someone is abusing a Medicaid recipient or private-pay resident in a Medicaid-funded long-term care facility or is defrauding the Arkansas Medicaid Program, contact the Arkansas Attorney General's MFCU.

Call (501) 682-7760
Call Toll-free 1-866-810-0016

Report all suspected incidents of neglect or abuse of a resident of a long-term care facility to the DHS Office of Long Term Care.
Call Toll-free 1-800-582-4887

To Report Suspected Medicare or Medicaid Fraud:
Call the ASMP Hotline Toll-free 1-866-726-2916
Or Write to Address Below